

**CHILD DEVELOPMENT SERVICES (CDS) CHILD HEALTH ASSESSMENT**

For use of this form, see AR 608-10; the proponent agency is DCSPER.

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 10, United States Code, Section 3013.  
**PRINCIPAL PURPOSE:** Information is used by DA personnel to: (1) verify child health status and currency of immunization per admission requirements; (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program.  
**ROUTINE USES:** Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.  
**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR ( <i>Last, first, MI</i> )	TELEPHONE ( <i>Home</i> )	TELEPHONE ( <i>Duty</i> )
NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN	ADDRESS ( <i>Include ZIP Code</i> )	TELEPHONE

**CHILD HEALTH INFORMATION (*Sponsor*)**

NAME OF CHILD	BIRTH DATE	SEX
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HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN (*If yes, explain circumstance(s) and current status*)☐ YES ☐ NOHAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM ☐ YES ☐ NO**IMMUNIZATION DATES (*List Month and Year*)**

DPT	_____	_____	_____	_____
TOPV	_____	_____	_____	_____
MMR	_____	_____	_____	_____
TINE	_____	_____	_____	_____

**DISEASES AND ILLNESSES (*Check Yes, or No*)**

CHICKEN POX	<input type="checkbox"/> YES <input type="checkbox"/> NO	RUBELLA	<input type="checkbox"/> YES <input type="checkbox"/> NO	TEN-DAY MEASLES	<input type="checkbox"/> YES <input type="checkbox"/> NO
MUMPS	<input type="checkbox"/> YES <input type="checkbox"/> NO	POLIOMYELITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	RHEUMATIC FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO
SCARLET FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO				

OTHER (*List*) \_\_\_\_\_**CHRONIC ILLNESSES AND CONDITIONS (*Check Yes, or No*)**

VISION PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	AUDITORY PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
ORTHOPEDIC PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO
SEIZURE DISORDER	<input type="checkbox"/> YES <input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO

OTHER (*List*) \_\_\_\_\_ALLERGIES (*List*) \_\_\_\_\_**COMMENTS/INDICATE FREQUENCY**

COLDS

EAR ACHES

STOMACH ACHES

HEADACHES

## COMMENT/INDICATE FREQUENCY

DIARRHEA

CONSTIPATION

BED WETTING

SLEEP DIFFICULTIES

POOR EATING HABITS

TANTRUMS

EXCESSIVE ACTIVITY

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS *(Medical Staff)*

ILLNESS/CONDITIONS	EARLY SYMPTOMS	RECOMMENDED CDS PROCEDURES

COMMENTS

ON-GOING MEDICATION *(Medical Staff)*

TYPE	DOSAGE	FREQUENCY	CDS ADMINISTERED

## MEDICAL STAFF COMMENTS

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ VISION \_\_\_\_\_ HEARING \_\_\_\_\_

## SPECIAL MEDICAL CONSIDERATIONS

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CDS PROGRAMS

REFERRAL FOR CHILD FIND SCREENING ☐ YES ☐ NO

## MEDICAL STATEMENT

The above named child has been given a routine medical examination and has been found free of infectious or contagious diseases, and to be capable of participating fully in CDS programs with the exception listed above.

SIGNATURE OF MEDICAL FACILITY REPRESENTATIVE

DATE

SIGNATURE OF SPONSOR

DATE